network
NETWORK 23 JULY 2008

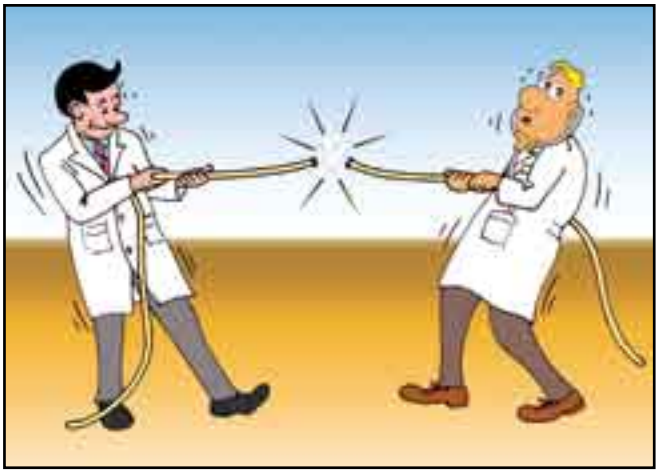
Special supplement in this issue

# Is 'recovery' splitting the drug treatment field?

**There is an interesting debate in the drug treatment field at the moment about the meaning of 'recovery'. Can the definition of recovery include those who are on maintenance substitute medication? This discussion has its roots in the debate about what was felt to be 'good treatment'. SMMGP have always thought that good treatment should be patient-led, and should involve a spectrum of approaches ranging from abstinence to harm reduction. This is a view held by large sections of drug treatment professionals; however it seems that some at both ends of this spectrum see their approach as the 'right' approach and the discussion regarding abstinence philosophies as opposed to harm reduction philosophies has somewhat polarised the field. There is a feeling on the one hand that treatment services are failing to offer abstinence as an option for patients, and on the other hand that the emphasis on abstinence is eroding a harm reduction approach and influencing policy (the Scottish Drug Strategy and the Conservative Party document 'Breakthrough Britain' contain a far greater emphasis on abstinence than the current drug strategy in England).**

In response to this polarisation, the UK Drug Policy Commission (UKDPC) felt that a definition of 'recovery' that would encompass all aspects of the debate might help to unite the field. In March 2008 the UKDPC invited 16 individuals to take part in a two-day consensus meeting; the group encompassed a wide range of perspectives and included: several people in recovery; family members of people in recovery; and professionals from services providing the full range of care and support. Services represented included: those using a 12-step approach; maintenance prescribing; general practice; residential rehabilitation; peer and family support groups; and service commissioners. Participants also came from different parts of the United Kingdom and were of different ages and cultural backgrounds.

The aim of the discussion was to identify common ground and develop a shared understanding of the process of recovery that would encompass the wide range of individual experiences and the differing contributions that treatment and support services make to assist those to achieve and maintain recovery.



The result of the meeting is a consensus statement:

**"Recovery is a process, characterised by *voluntarily maintained control over substance use,* leading towards health and well-being and participation in the responsibilities and benefits of society"**

More detailed information can be found on
http://www.ukdpc.org.uk/Recovery_Consensus_Statement.shtml

SMMGP is keen that the debate regarding recovery is productive and we invite people to air their views on our website's ***online forums*** http://www.smmgp.org.uk/ in the hope that we can have an open debate that leads to a greater understanding of people's beliefs and to an improvement in the service we give to patients. To contribute to the debate we have included two views on recovery in this edition of Network. **Anthony Hewitt** discusses what we can learn from *natural recovery* by looking at the large numbers of people who become drug and alcohol free without the support of treatment services. **Mike Ashton** discusses the potential affect of the growing debate regarding recovery on the drug treatment field in his article *Flag in the breeze;* we have published this article as a four-page supplement.

While you are on our website, please ***join SMMGP for free***, and receive our regular clinical and policy up-dates, as well as being invited to participate in our regular members' survey, the next of which will be on the concept of recovery. The findings of the member' survey will be published in the next edition of Network, as well as on the website.

**Jim Barnard, Chris Ford, Kate Halliday,** SMMGP.

# Editorial

There are so many interesting articles in Network 23 that we have had to increase its size! We are excited to have a special four page supplement of Mike Ashton's article 'Flag in the breeze' in this edition of Network, and we hope that this, together with Anthony Hewitt's article, will encourage you to join in the debate about recovery on our online forum, www.smmgp.org.uk and in our members' survey (you can join online for ***free***).

**The 3rd Annual SMMGP Conference *Primary Care Drug Treatment - End of the line, or part of the journey?*** 26th September in Bristol is drawing closer. This is a must for people wanting to develop their primary care based substance misuse services and will look at a range of topics from where primary care fits within the treatment system to how to deliver 'added extras' such as employment advice and services for homeless people. For more information visit the courses and events section of our website www.smmgp.org.uk

The ***RCGP Management of Drug Users in Primary Care 13th Conference 'Meeting the needs of diverse populations: hard to reach or easy to ignore?'*** in Brighton this April was a lively and exciting event. The consensus amongst delegates was that providers need to do more to make access to services easier, and that this will involve listening to all groups of the communities we serve, in particular those who are the most socially excluded. For more information, including the conference statement and presentations, see the ***courses and events section of our website*** www.smmgp.org.uk and put the dates of the 14th conference in Liverpool ***7th and 8th May 2009*** in your diaries. The theme for next year's conference will be a return to the basics of primary care, 'Family medicine: from cradle to grave'.

**Finally Watch out for a Prison Special Edition of Network, commissioned by the National Treatment Agency, coming soon!**

Enjoy this issue! **Kate Halliday**

***Jim Barnard*** **outlines the results of our most recent reader survey which has given us some very useful feedback - and a big head! Ed.**

# SMMGP Network reader survey – we're great!

The results of our latest reader survey were very encouraging. For usefulness, readers rated network at a mean score of 4.5 out of 5 of which the median score was 5. Of the respondents, 98% thought we had the presentation right and 95% felt that we had the right balance between policy, clinical practice and research. There were some very helpful suggestions for improvement, including suggested new topics, and several people offered to write articles - we will be chasing you up! We don't like to blow our own trumpet but we like receiving comments like 'Ace', 'excellent journal' and 'informative, accessible and punchy'. The most negative comment was 'I don't do this type of work at the moment'. Honestly you don't have to give us such big heads. The full survey can be seen as part of our annual report which is now published on our web site. A big thanks to everybody who responded to the survey!

**Jim Barnard** SMMGP Policy Advisor.

# In this issue



We hope you enjoy this edition.

**Editor**

Don't forget to become a free member and receive regular clinical and policy updates - the newsletter can also be emailed to you – all for free www.smmgp.org.uk/membership

**Do drug and alcohol users need treatment services in order to become abstinent? *Anthony Hewitt* argues that the majority of people manage without our help, often deterred by the stigma of being in contact with treatment agencies, and a perception that services will be unhelpful. He suggests that services need to learn from the experience of people who manage a 'natural recovery' by offering a 'stepped care' approach, by concentrating more on positive health promotion messages, and by advertising our services in a more proactive manner. Ed.**

# Natural recovery: what can we learn from those who manage without us?

*Most people with drug and alcohol problems prefer to tackle their problems themselves, using treatment as a last resort. Can we acknowledge this and actively support self-change and empowerment?*

Across the country there have been needs assessments to establish how many people have drug problems. But if there are 5,000 problem drug users in your area, does that mean we need 5,000 treatment places? No, it doesn't - having a drug problem isn't the same thing as needing treatment.

There is an unquestioned belief that people with drug problems *require* our help, indeed that it's a crime if they are left to manage without it. But the evidence [1,2] is that a lot of people neither want nor need our help, and in forcing ourselves on them we may not actually be helping them.

Understandably, our beliefs about resolving drug problems are heavily influenced by our experience of the people who come to us for help, and they are often in a lot of trouble. But, the reality is that we only see the tip of the iceberg, and it would be a mistake to think that we can develop an understanding of the level of substance misuse problems based only on who we see presenting to us.

The fact is, most people (as many as 50 to 80 per cent)[1,2,3,4] who experience significant problems with drugs or alcohol (or for that matter eating, gambling and smoking) manage to get on top of these problems without input from specialists or self-help groups. And please note that this refers to 'proper' serious problems, not just dabbling.

The evidence for natural recovery comes from a range of studies, including some very large, random, general population studies [3,4] in a number of different countries. The breadth in the figures comes from variations in definition of what counts as treatment [3], but the fact is that the majority of people overcome their problems without the help of Government strategies and without our help.

> ***"All recovery is essentially 'self-change' and the role of treatment is to support this process – and indeed, this is all that treatment can hope to do"***

In general, the more severe and complex the addiction, the more professional help may be needed [1,3]. The concept of *stepped care* suggests that a hierarchy of approaches from self help and minimal interventions to structured treatment should be offered, with the most complex drug and alcohol problems requiring the most intensive treatment approaches. But self-change is possible and can and does occur with any kind or level of addiction [5]. And self-change does not only result in abstinence, but can also result in sustained, long-term, controlled usage without apparent problems [1,3,6].

**Natural recovery, spontaneous remission, self-change:** There are many terms used in relation to the phenomenon of people overcoming addiction without accessing drug treatment – but what are implications of this process? What can we learn from the studies of those who managed to overcome their problem without specialist help?

Research in this area often seeks to identify why people didn't seek specialist help, and there is clearly much we can learn from the findings to improve the take-up of services, particularly for groups such as stimulant users and ethnic minority users who could benefit from services but do not appear to be taking them up. There are a number of reasons identified for individuals not seeking professional help including:

**Stigma:** No one should have to experience stigma, and shame is only productive in small doses (but it can be a good thing if people resist identification with their drug problem, acting as a motivator towards healthier choices and away from less healthy ones). There is a message here for service providers; we need to look at how we are unintentionally stigmatising those who do come to us for help.

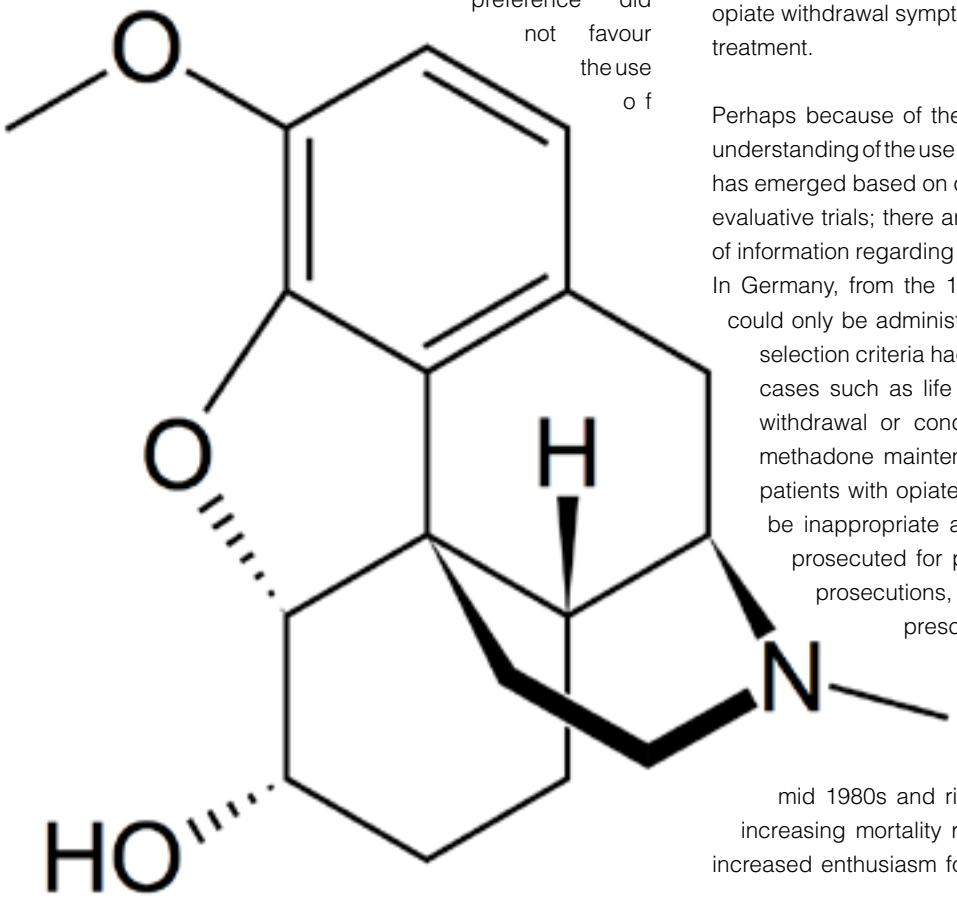
**Independence:** None of us likes being told what to do, so why should our clients like it, even when we're doing it nicely or 'for

*...continued on page 13*

***Roy Robertson*** **discusses the potential for the use of dihydrocodeine for substitute prescribing, and calls for further studies to investigate its effectiveness. For more on this subject see Chris Ford's Dr Fixit page 14. Ed.**

# Codeine and dihydrocodeine in opioid dependence treatment

Although the use of methadone for the treatment of opioid dependence syndrome is not new it is a treatment that has been characterised by considerable clinical, organisational and political problems. Regulations have, to a certain extent, constrained the logical development of methadone treatment in most Western countries and legal restrictions have meant that only a small proportion of those who might be clinically eligible have been engaged in treatment. In some countries treatment has been withheld completely for reasons which have often been non-medical, ideological or entangled with prejudicial views on the management of individuals using illegal drugs. There has, therefore, been a demand for an alternative therapy in jurisdictions where methadone was not available and in those countries where doctor or patient preference did not favour the use of this drug. There is also an increasing recognition that methadone is a drug with side effects which are at times dangerous, at other times unacceptable or unattractive to patients, and which is governed by restrictions and regulations which make it inflexible and therefore unattractive for substitute prescribing. The introduction of buprenorphine gave us an alternative, helping us to tailor treatment to individual patient needs, and this may have lead to the consideration of other drugs which could be an appropriate opiate substitute. These include injectable diamorphine or hydromorphone, long acting morphine sulphate and codeine and dihydrocodeine preparations.




In the United Kingdom codeine and dihydrocodeine, in the doses available in tablet form, are both Class B Schedule 5 drugs (Misuse of Drugs Act 1971), the injectable form of dihydrocodeine is a schedule 2 drug. Both are used as self-medication for patients who have symptoms of pain or distress and can lead to dependency problems from overuse or inappropriate use. Many individuals who have used other opiate drugs report the use of non prescribed codeine or dihydrocodeine as an interim or fall back measure when their preferred drug is not available. In France and Germany where the development of opiate substitute treatment in non-specialist centres was poor in the 1980s and 1990s, codeine and codeine derivatives were widely used in self-treatment situations. In the recent past dihydrocodeine has been used as a prescription drug for patients with opiate dependency, either because methadone was unavailable, or for other reasons such as patient preference, intolerance to methadone or avoidance behaviour. There is, therefore, considerable clinical experience in the use of codeine, and in particular dihydrocodeine, as a formal response to patients with opiate withdrawal symptoms or requiring maintenance substitute treatment.

Perhaps because of the absence of scientific evidence based understanding of the use of codeine and dihydrocodeine treatment has emerged based on clinical experience rather than on proper evaluative trials; there are, however, a number of useful sources of information regarding the use of codeine and dihydrocodeine. In Germany, from the 1980s until the early 1990s, methadone could only be administered to drug users after highly specific selection criteria had been met. These included emergency cases such as life threatening conditions associated with withdrawal or conditions involving severe pain. Use of methadone maintenance therapy for medical treatment of patients with opiate addiction problems was considered to be inappropriate and there were cases of doctors being prosecuted for providing this treatment. As a result of prosecutions, some general medical practitioners prescribed codeine or dihydrocodeine to addicted patients, as these drugs were outside the restricted regulations. It was perhaps the emergence of HIV/AIDS in the mid 1980s and rising drug addict criminality, as well as increasing mortality rates among drug users, that led to an increased enthusiasm for prescribing dihydrocodeine for those

at risk [1,2]. Case reports and personal accounts of street drug culture in France prior to the development of buprenorphine prescribing in family practice presents a picture of codeine analgesic misuse co-existing with illegal heroin problems. Dihydrocodeine use for treatment of opiate users has also been reported in the UK in general practice and the prison service for some time [3.4.5]. It has been used as a maintenance treatment and as an agent in reduction schemes where patients are either in custody or reaching a low dose of methadone.

More substantial evidence of dihydrocodeine as a substitute prescription in opiate dependent individuals comes from a recently conducted formal randomised controlled trial which was carried out in Scotland to test the efficacy of dihydrocodeine against the standard therapy methadone [6]. This trial was extremely useful in identifying dihydrocodeine as an alternative to methadone with apparently equivalent efficacy when used in maintenance treatment. The principal outcome measures were those usually used in testing the value of methadone or buprenorphine namely retention in treatment, reduction in use of illegal drugs and injecting, reduction in criminal behaviour and overdose, and improvement in general health and social conditions in the previous six months. Employment was included as an outcome measure but although results were similar in both groups, rates of achieving employment was low in both groups. Perhaps one of the most useful contributions of the trial was identifying a suitable equivalent dose between methadone and dihydrocodeine and deriving a suitable treatment range for dihydrocodeine substitution. The trial concluded that an equivalent dose was 2.5mg methadone to 30mg dihydrocodeine. The dose range used in the trial was clinically determined in a way similar to experience with methadone and the dose of methadone ranged from 40mg to 150mg and from 450mg dihydrocodeine to 1800mg. At the higher doses 60mg or 120mg long acting tablets of dihydrocodeine were used. It was clear throughout the study that patients were able to tell the difference between dihydrocodeine and methadone and, in a way similar to the case reports of buprenorphine, patients described improved mental clarity on dihydrocodeine as compared to methadone. Follow up was possible at six monthly intervals from 6 months to 42 months, confirming the veracity of one of the principal outcome measures, retention in treatment.

Interestingly there has been some recognition for the use of dihydrocodeine in opiate substitute treatment in recent policy statements and official documents. The Department of Health 2007 Clinical Guidelines begin to acknowledge its possible potential and encourage further exploration of its use. The recently published Scottish policy statement on the management of drug users also includes a commitment to alternatives to methadone as a treatment option although specific mention of dihydrocodeine was excluded in the final draft [7].

Inevitably for General Practitioners and other prescribers there are some inhibitors to moving outside the standard treatments of methadone or buprenorphine. Dihydrocodeine does not have a product licence for treatment of opiate dependence and there is concern amongst some that it might be a drug that will be prone to diversion. It is suggested by some that it is likely to be a drug that will be easy to misuse and that patients will fail to achieve the control attributed to methadone treatment. However there is little formal evidence to support these views and the trial cited above indicates that treatment failure with dihydrocodeine may be due to inadequate doses (a problem identified in recent years with methadone treatment failures).

Dihydrocodeine does however have several attractions. It may be less appealing to inject as users of the drug have reported that it causes nausea and dysphoria rather than euphoria when used intravenously. Although it is a shorter acting drug in most preparations this is seen by some as an advantage. The requirement to be taken more than once a day is not reported by patients as being inhibitory and the onset of withdrawal symptoms is often not seen as a disadvantage. It may indeed allow a psychological normalisation effect and a paradoxical feeling of control. However the need for dihydrocodeine to be taken more than once a day does make it a difficult drug to supervise creating a potential difficulty, particularly at the beginning of treatment. Some would argue that taking medication frequently may be reinforcing and could make the habit of drug use more persistent. Further studies would be useful to clarify optimum doses and indications but doctors with appropriate competencies might well consider it as a useful alternative to methadone or buprenorphine.

Finally, and not insignificantly, dihydrocodeine offers additional benefits for the patient; for access to a more normal lifestyle which includes employment, holiday travel and the privacy expected by most people, dihydrocodeine has advantages. It is minimally controlled under statute, it is indistinguishable from medicines prescribed for other conditions and it is portable and flexible. In attempting to normalise the lives of patients recovering from opiate dependency these characteristics should not be underestimated.

**Dr Roy Robertson,** Reader, Department of Community Health Sciences, Edinburgh University.

**References**

1. Gerlach. A drug substitution treatment in Germany: a critical overview of its history, legislation and current practice. *Journal of Drugs* 2002 – Volume II – Pages 503 – 522.

2. Krausz, M., Verhein, U., Degkwitz, P., Haasen, C., Raschke, P. Maintenance treatment of opiate addicts in Germany with medications contains codeine - results of a follow up study. *Addiction;* 1998 93(8): 1161-1167.

3. Macleod, J., Whittaker, A., Robertson, J. R. Changes in opiate treatment during attendance at a community drug service - findings from a clinical audit. Drug and *Alcohol Review* 1998 17:19-25.

4. Matheson, C. Pitcairn, J., Bond, C. M., van Teijlingen, E., Ryan, M. General practice management of illicit drug users in Scotland: a national survey. *Addiction* 2003 98 (1): 119-126.

5. Department of Health and HM Prison Service, London A Pharmacy Service for Prisoners 2003.

6 Robertson et al Addressing the efficacy of dihydrocodeine versus methadone as an alternative maintenance treatment for opiate dependence: a randomized controlled trial *Addiction* 2006 Dec;101(12):1752-9.

7. Scottish Government. The Road to Recovery. 2008 Edinburgh

***Noel Craine*** **asks the question 'Why do drug users share needles and syringes?' and examines some of the factors that can lead to risk behaviours. He highlights the impact of needle exchange on reducing the risk behaviours of injecting drug users and argues that in order to build on this we need to focus not simply upon the individual's behaviour but to look towards cultural changes amongst drug using communities. Ed.**

# Why do drug injectors share needles and syringes?

It is now well established that the sharing of needles and syringes is a major route through which blood borne viruses are transmitted between injecting drug users. In the most recent update of the annual surveillance report 'Shooting Up', one in six drug injectors reported sharing needles and syringes and one in four homeless injectors reported sharing in the last month[1]. It is thus clear, despite two decades of needle and syringe provision and widely disseminated health care messages discouraging sharing, that this behaviour is still common. Why might this be so?

It is, at the outset, perhaps worth highlighting the difficulties and care that should be taken in interpreting research on injecting risk behaviour. Whilst injecting drug users' self-reports are generally considered sufficiently reliable for quantitative studies[2] the self-reporting of direct needle sharing may be subject to greater bias than more socially acceptable behaviours. Who asks questions, how questions are phrased and where interviews are carried out may all influence the willingness of individuals to report risk behaviour. Qualitative studies can allow a more nuanced exploration of risk behaviour, however they can be limited in their focus to a particular group of people and care must be taken when extrapolating findings to the population level and in determining causality. In addition, researchers in Scotland have reported accidental sharing that may go unnoticed and thus unreported[3].

Notwithstanding these limitations, there is much to be learnt from the research; we can now be sure that needle sharing is common, however, when trying to understand the more subtle interactions between behaviour and the environment there is greater uncertainty. It can be argued that the factors that influence the precipitation of needle and syringe sharing fall into the following categories; structural factors, marginalisation factors, social factors and drug driven factors.

## Structural factors

**Homelessness:** A clearly described co-factor of injecting risk in the UK is homelessness. Recent research in Wales demonstrated highly elevated hepatitis C virus (HCV) incidence and injecting risk behaviour amongst homeless injectors in comparison to housed injectors[4]. A recent study of HCV prevalence in multiple sites in England reported an association between homelessness and HCV infection[5]. The chaos associated with the lives of many homeless injectors can contribute to poor uptake of clean needles and increased risk behaviour. Homeless individuals are more likely to inject in public places and this is associated with frequent and hasty injecting, and with needle sharing[6,7,8].

**Availability:** Clearly in order to obtain clean injecting equipment it is essential that such equipment is readily available and can be conveniently accessed[9]. Both geographical and opening time limitations to needle and syringe availability may increase the likelihood of needle sharing. Access to needles may be restricted to working hours whilst drug use frequently occurs outside of these hours. The challenge of providing clean equipment may be compounded in communities where anonymity may be difficult to achieve for exchange users.

## Marginalisation factors

**Deprivation:** A more subtle influence on risk behaviour may be the wider social marginalisation of drug injectors. Injecting drug use is strongly correlated with social deprivation. Thus drug use must be considered alongside those factors associated with deprivation, for example poor educational attainment and high levels of unemployment. It is straightforward to hypothesise how these factors may influence risk behaviour but more challenging to demonstrate causal links. Low self-esteem, a sense of the inevitability of infection and a lack of understanding of the importance of safe injecting may all lead to an increase in the likelihood of risky behaviour. The high risks associated with disadvantage are indicated within a recent survey which found that approximately one third of drug injectors recruited to a large study in Wales had grown up within the care system[10].

Mental health: Drug users with mental health problems are likely to be at high risk of needle sharing. Mental health problems can contribute to social marginalisation and may compound a drug user's judgements around risk behaviour.

## Social factors

Drug use takes place within a social context. The interpersonal relationships between drug injectors will shape the risk environment. Research has suggested that patterns of sharing may vary amongst individuals with different lengths of injecting careers and with gender[11]. Women may, through the social dynamics of sexual relationships, be at greatest risk of receptive syringe sharing[12]. Likewise injectors early on in their injecting careers may be reliant on more experienced injectors to inject for them, provide injecting equipment and provide drugs. This can lead to loss of control of an individual's own risk environment (for a valuable exploration of context see McKeganey & Barnard 1992[13], and for a contemporary insight see Taylor et al. 2004[3]).

## Drug related factors

The drugs used by injectors can influence risk behaviour. Opiate withdrawal may increase the risk of needle sharing[14]. Drug intoxication may compromise decisions around risk behaviour. Stimulant use, for example amphetamine injection, crack cocaine injection and speed balling (heroin and crack or cocaine together) can lead to binges of drug use. In binges, risk may increase over time with increased intoxication[15]. The repetitive nature of sustained stimulant injection necessitates greater amounts of clean injecting equipment and, as it may involve other injectors, increased opportunity for needle sharing.

## How should this research inform the health care response in the UK?

It could be argued that it is time to focus away from individual based intervention to concentrate upon achieving peer group and community level changes in behaviour. Implicit in reductions in risk behaviour across the drug using population is the creation of safer environments; thus widely available needle and syringe exchange is essential. For the highest risk environments, in particular those experienced by homeless injectors, there is an argument for the piloting and evaluation of safe injecting facilities across the UK. Cultural changes are needed within drug using communities. Safe injecting as a behavioural norm must grow from within the drug using communities in the UK. Widely available and high quality drug treatment services must continue to play a central role in reducing the harms associated with injecting and peer education requires more serious attention.

These aspirations may seem overly optimistic. However it is important to recognise that efforts to date have impacted upon risk behaviour and on subsequent drug borne viral infection; both HIV and hepatitis C prevalence among drug injectors are lower in the UK than in many neighbouring countries. This must act as a spur to ensure the strengthening and refining of what has gone before, as well as striving to adopt innovative responses to reduce injecting risk behaviour.

**Dr Noel Craine**
Research Scientist, National Public Health Services, Microbiology Bangor.

The views expressed in this article are those of the author and do not necessarily represent those of the National Public Health Services Wales

### References

1 Health Protection Agency Shooting up. Infections among injecting drug users in the United Kingdom 2006. An update: 2007.

2 Darke S. Self-report among injecting drug users: A review. *Drug and Alcohol Dependence* 1998 ; 51, (3) 1: 253-263.

3 Taylor A, Fleming A, Rutherford J, Goldberg D Examining the injecting practices of injecting drug users in Scotland. *Scottish Executive Effective Interventions Unit,* 2004. Available at: http://www.scotland.gov.uk/Resource/Doc/47210/0013525.pdf

4 National Public Health Service for Wales The incidence of HCV, HBV and HIV in South Wales. *Report for the National Public Health Service for Wales.* 2007. http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=25483

5 Hickman M., Hope V., Brady T., Madden P., Jones S., Honor S. et al. Hepatitis C virus (HCV) prevalence, and injecting risk behaviour in multiple sites in England in 2004; *Journal of Viral Hepatitis* 2006 (OnlineEarly Articles).

6 Klee H., Morris J. Factors that characterise street injectors. *Addiction:* 1995 90:837-841.

7 Rhodes T., Kimber J., Small W., Fitzgerald J., Kerr T., Hickman M., et al. Public injecting and the need for 'safer environment interventions' in the reduction of drug-related harm. *Addiction;* 2006 101:1384-1393.

8 Wright N., Tompkins C. Exploring risk perception and behaviour of homeless injecting drug users diagnosed with hepatitis C. *Health and Social Care in the Community;* 2005 13:75-83.

9 Hutchinson S. J. Taylor A.;Goldberg D. J. Gruer L. Factors associated with injecting risk behaviour among serial community-wide samples of injecting drug users in Glasgow 1990–94: implications for control and prevention of blood-borne viruses. *Addiction,* 2000 95,(6):931-940.

10 National Public Health Service for Wales Needs assessment of harm reduction and health care services for substance misusers across Wales. *Report for the National Public Health Service for Wales.* 2007. http://www.wales.nhs.uk/sites3/page.cfm?orgid=457&pid=25483

11 Frajzyngier V, Neaigus A. Anna Gyarmathy V, Miller M and Friedman SR. Gender differences in injection risk behaviors at the first injection episode *Drug and Alcohol Dependence,* 2007 Volume 89, Issues 2-3, Pages 145-152.

12 Maher L., Jalaludin B., Chant K.G., Jayasurija R., Sladden T., Kaldor J.M. et al. Incidence and risk factors for hepatitis C seroconversion in injecting drug users in Australia. *Addiction;* 2006 1:1499-1508 .

13 McKeganey N, Barnard M. Aids, Drugs and Sexual Risk : Lives in the Balance. *Open University Press* 1992.

14 Craine, N., Walker, M., Carnwath, T., Klee, H. Hepatitis C testing and injecting risk behaviour: the results of a UK based pilot study *International Journal of Drug Policy* 2004 15 (2) 115-122.

15 Klee, H. & Morris, J. Amphetamine misuse: the effect of social context on injection related risk behaviour. *Addiction Research,* 1997 4(4), pp.392-342.

***Stephen West*** **examines the reasons why people with disabilities are under-represented in drug treatment agencies despite the fact that evidence points towards higher than average substance misuse problems amongst some disabled groups. He argues that improving access to premises and educating ourselves in 'disability etiquette' would be a good starting point for drug treatment agencies to improve their provision of services for people with disabilities. Ed.**

# Barriers to addiction treatment and persons with disabilities: an overlooked problem


During the past several decades, we have seen tremendous changes in both research and clinical practice in the addictions field. Our ability to serve clients with addictions concerns has increased with greater emphasis on evidence-based practice, knowledge about the unique presentations of particular groups, and our willingness to explore new avenues in treatment, prevention, and research. Advances in our understanding of the multifaceted nature of substance misuse as a bio-psycho-social concern have facilitated attempts to address such issues from a holistic perspective. There has been a veritable explosion of research articles and publication outlets, and today information is readily attainable on topics that a few short years ago were only imaginable. Yet, a growing body of research has developed to suggest that a large segment of the population has been overlooked in these advances. Further, this new research paints a picture not only of a population forgotten or unnoticed, but also of a population that has some of the greatest rates of misuse and addiction, and one of the lowest rates in terms of treatment participation.

This group is a collective of individuals that have in common a status as persons with disabilities (PWDs). In the UK and other post-industrial and industrialised nations, PWDs represent a large and varied group, typically 10- 20% of the population. Using the guidelines for defining disability from the Disability Discrimination Act 1995, a disability is any physical or mental impairment that has a substantial and long-term adverse effect on an individual's ability to carry out normal day-to-day activities. 'Long-term' is meant to be at least one year in duration, and normal activities includes such basic actions as eating, dressing, and bathing. Estimates of the number of PWDs in the UK place the figure at as great as 11 million, or almost 19% of the more than 60 million persons in the total population[1]; greater accuracy in these estimates should accompany the Office for National Statistics longitudinal disability survey commissioned by the Office for Disability Issues, to be undertaken at the earliest in 2010. Whilst no comprehensive survey of substance misuse by PWDs is available, small scale studies suggest the number could be quite staggering.

For example, the rates of alcohol and other drug misuse by PWDs among persons with developmental disabilities such as mental retardation and autism have been estimated to be as high as 14%[2, 3]. The rates of substance misuse and addiction by persons with sensory disabilities have been found to be substantially greater than the rates among the general non-disabled population and individuals with visual impairments and those with auditory impairments both have rates of abuse and addiction that are at least 50% or more[4, 5]. Particularly high rates of abuse and addiction are found in those persons with traumatically acquired disabilities. In the cases of both spinal cord injury (SCI) and traumatic brain injury (TBI), the rates of co-occurring substance misuse have been reported to be as great 50- 60%[6-8]. In many cases, the abuse of alcohol and other drugs pre-dates the disabling condition. As many as 60% of TBI and SCI cases are acquired while the individual is intoxicated.

As with other populations, PWDs who misuse or are addicted to alcohol or other drugs face a wide range of negative outcomes. In addition to common health concerns such as hepatitis, cirrhosis and gastritis, PWDs face unique challenges both in terms of their occurrence and impact. Distinct concerns include delays in adjustment to acquired disability, increases in the likelihood of obtaining secondary disabling conditions, and increases in the likelihood of pressure ulcers, urinary tract infections, and a host of other disability-specific health concerns. Negative outcomes that are common to other populations but which carry additional concern for PWDs include the increased likelihood of being the victim of crime, increased levels of unemployment, and increased occurrence of family dysfunction.

Given these figures, one might expect to encounter large numbers of PWDs in treatment centres across the country. In fact, given the large numbers of persons with physical disabilities who misuse and who are addicted to substances, the sight of wheelchairs, canes, and other assistive devices should be common in any treatment setting. As practitioners know, however, this is not the case. Although studies specific to the UK are lacking, research from Canada and the US indicate that PWDs are significantly underrepresented in the treatment population. Six studies from the U.S. and Canada suggest that PWDs' treatment participation rates range from 1.5 - 8.2%; rates that are statistically less than would be expected when considering the size of the

*...continued on page 9*

network
SPECIAL SUPPLEMENT

# A flag in the breeze

## *Mike Ashton hoists a small flag into Britain's addiction treatment policy breeze.*

**In this special supplement *Mike Ashton* gives his views on how *the debate on recovery may influence drug policy in the UK.* He argues that the debate regarding abstentionist and harm reduction philosophies could lead to significant changes in the UK drug treatment field. Ed.**

Stick your finger in the air and if you've wet it sufficiently you'll feel a new direction to the drug treatment policy breeze, a potentially powerful confluence of previously unaligned air streams. Old-style abstentionism, resurgent in the wake of receding national imperatives to curb infection and cut crime, is filling its lungs with the fresh air of the 'recovery' movement, and so too are our policymakers, aware that Britain can no longer afford for people *not* to recover – or at least, not *be seen* to recover – get off benefits, exit treatment and make way for patients we couldn't otherwise afford to recruit.

Each lends a mutually reinforcing puff to the other. Recovery advocates, who passionately desire a better life for the patients and for their families, see influential converts and allies. For its hitchhikers, the shiny vision of recovery and its power to inspire, provide renewed impetus and respectability. Abstentionism, ever present in a policy environment built on prohibition, can emerge more forcefully clothed as a prerequisite for an unchallengeable good – recovery from addiction. For the policymakers, recovery provides a benevolent rationale for the new treatment objective: to get rid of the patients.[1]

### Ground conceded, ground occupied

Today's abstentionism has co-opted the language of recovery, hitching abstinence to an optimistic vision of a new life, while still insisting that this must be free from illegal drugs and free from their legal substitutes.

Partially aligning themselves with the abstentionists' abhorrence of anything which "would make drug use easier"[2] and of methadone maintenance as "perpetuat[ing] addiction and dependency",[3] the NTA, the government[4] and leading treatment providers[5] also agree that *true* recovery means no longer being prescribed substitute drugs and no longer being in treatment.

No matter how circumspectly, the addiction treatment patient is being stigmatised by virtue of still being a patient, and with them the treatment expressly dedicated to maintaining that status, maintenance prescribing.[6] Yet exiting treatment still using illegal drugs doesn't look much like recovery either. The logic of the situation leaves just one truly acceptable outcome – off illegal drugs, off substitute drugs too, and out of treatment.

By virtue of conceding the ground on long-term substitute prescribing, our leaders find themselves on the turf of The New Abstentionists, masters at eliding abstinence with recovery as if one was predicated on the other.[7]

1 'Recovery' has had greater currency in Scottish policy circles while in England the new drug policy talked of the overlapping concept of 'reintegration', but at the Drug and Alcohol Today exhibition in London on 1 May 2008, Home Office minister Vernon Coaker repeatedly referred to 'recovery'.

2 Professor Neil McKeganey condemning the prospect of injecting rooms in Scotland.

3 Gyngell G. *Breakthrough Britain. Ending the costs of social breakdown. Volume 4: addictions*. Policy recommendations to the Conservative Party. Social Justice Policy Group, 2007.

4 National Treatment Agency for Substance Misuse board meeting 11 March 2008. Papers describe the new English drug strategy as "equally comfortable with abstinence and maintenance routes *through* treatment, but ultimately always focused on maximising the individual's potential to overcome dependency, *leave* treatment and live a *fully independent life*" (italics added).

5 Re*sidential Rehabilitation and the national drug strategy*. 19 October 2007. "What [methadone maintenance] treatment does not appear to do, however, is to provide a true exit from the interrelated behaviours, harms, risks and lifestyle norms associated with dependent drug use ... MMT offers better life prospects than class A dependent drug use; it is equally true that abstinence offers better life prospects than MMT."

6 Lavack A. "Using social marketing to de-stigmatize addictions: a review." *Addiction Research & Theory*: 2007, 15(5), p. 479–492: "a person who is stigmatized is a person whose social identity, or membership in some social category, calls into question his or her full humanity – the person is devalued, spoiled or flawed in the eyes of others" – reminiscent of the not "fully independent" formulation of the NTA.

7 For an example see: McKeganey N. "Recovery is key." *Druglink*: February/March 2008, where he moves in six quick steps from recovery through overcoming dependence to no illegal drug use to drug-free, then to abstinence and finally to defining that as also excluding substitute medication, as if each was either the same as or predicated on the other.

## Self-fulfilling prophecy

This would all be fine if as a result of these alliances, recovery with no downsides really was the prospect awaiting our 200,000 odd patients, and maybe that's how it will turn out. But maybe not. The problem is that curtailing treatment, and placing recovery on the pedestal of abstinence – not just from illegal drugs but from their legal substitutes – threaten *actual* recovery at the same time as they adopt and amplify its rhetoric.

Patients who could have recovered on methadone may be denied both the practical and the psychological resources to do so. Stigmatised people are *avoided*, not nurtured and embraced into mainstream society,[8] and because we are our relationships, stigma is internalised as wilting self-efficacy or protective isolation.

The combination is likely to make it harder to leave treatment successfully and to further deter treatment entry (already a near last-ditch resort), leading to greater and less easily reversible deterioration before help is sought. More directly, pressure to terminate treatment could leave tolerance-free ex-patients at greater risk because for them too, the resources are not there to protect them.

Not only have we been here before, but so have others. When in the late 1990s New York's mayor Rudolph Giuliani moved to curtail methadone treatment, to predict what might happen, researchers trawled through the back catalogue of studies of discharge from the treatment. They concluded that as things stood, it would be "unwise to structure methadone programs and their financing so as to discourage or impede long-term maintenance, and at the same time to pressure patients overtly to accept abstinence by heralding its supposed desirability or superiority".[9] Post-discharge relapse was the norm and with it death, disease and social deterioration.

The paper's subtitle – "Lessons Learned, Lessons Forgotten, Lessons Ignored" – is as applicable to some in Britain today as it was then to New York.

Another lesson learned there is that denigrating methadone patients as by definition *un*recovered self-fulfillingly impedes their recovery. In the mid-90s experts who reviewed the literature for the state of New York concluded that what held patients back from working and doing all the other things the rest of us do (in today's language, what obstructed their recovery) was not the medication or their dependence on it, but stigma in relation to the addict and the treatment. "Negative societal responses may be more significant contributors to any functional limitation patients may experience than any directly detrimental effects of chronically administered opiates, which our review suggests are of minimal or no functional significance."[10]

Tainting the new breeze is the whiff, not of recovery and reintegration, but of the relapse, exclusion, illness and overdose repeatedly documented in the studies. No one actually wants this to happen. But there's a strong possibility it will, as the product of mal-aligned forces within the drug policy arena and deficiencies and resistances outside. Coincidentally, at the same time the tools are being made available to obfuscate the consequences and the responsibility.

## Water to wine

At a population level, the sole national indicator[11] dedicated to measuring the success of the treatment system allows us to declare victory regardless. Its standard for successful emergence from treatment – a planned discharge – often means nothing of the sort. In Cheshire and Merseyside (regions with unusually long series of data compatible with the national monitoring system), an even higher standard – drug-free planned discharge – was quickly followed by relapse and return to treatment at about the same rate as unplanned drop-out.

As currently constructed, such failures are not just hidden from the indicator, but could be recorded as successes. Only the final discharge status within a year is counted, closing the indicator's eyes to relapses within the year, and relapses and returns to treatment across years are recorded as yet another successful patient recruitment, which can once again be followed by a successful planned discharge or retention.

What this does to the system was expressed recently by a drug action team coordinator, local conduits for the national policy: "... yes we keep them for 13 weeks, yes they then get discharged, yes they end up back in treatment again within about three months. Do we spend DAT meetings talking about this? No, what we talk about are the central targets not the effect the targets are having on our services and not what the targets should be looking at." [12]

The interesting thing is that all this dangerous failure can

8 Lavack A. "Using social marketing to de-stigmatize addictions: a review." *Addiction Research & Theory*: 2007, 15(5), p. 479–492: "A stigma is usually attached to undesirable qualities, and a defining immediate reaction to stigma is avoidance of the stigmatized person … resulting in … social exclusion."

9 Magura S. et al. "Leaving methadone treatment: lessons learned, lessons forgotten, lessons ignored." *Mount Sinai Journal of Medicine*: 2001, 68(1), p. 62–74.

10 Gordon N.B. *et al.* "Functional potential of the methadone-maintained person." *Alcohol, Drugs and Driving*: 1995, 11(1), p. 31–35.

11 In PSA Delivery Agreement 25. There are of course other related national indicators and local performance benchmarks. But this one matters because on it depends 75% of the allocation of central funds to local areas (McGrail S. Ever Decreasing Pools. 12 January 2008. http://homepage.mac.com/smcg1967/Sara%20McGrail/page14/files/4fb83a7485081de7989e4ef462293581-15.html)

12 Inspecting the field - Harm Reduction and Commissioning Systems. http://homepage.mac.com/smcg1967/Sara%20McGrail/page14/files/876a42b7f0139865094b3e52afc3e243-32.html, 12May 2008.

happen without affecting target-meeting, so can be ignored by those responsible for meeting the targets. Not surprisingly, their attention is drawn to the national indicator instead, which dominates the funding allocation to their areas.

At an individual level, we have decided we can blame the drug user if the treatments we provide fail to engage them, or if they fail to emerge (staying is no longer good enough) transformed and recovered.

The new English drug strategy was at pains to be "clear that drug users have a *responsibility* to engage in treatment in return for the help and support available". Once engaged, "In return for benefit payments, claimants will have a *responsibility* to move successfully *through* treatment and into employment". (All italics added). Holding them accountable via the benefits system creates a win-win situation for the Treasury if not for the patient: if they succeed, we save money because they are out of treatment, off benefits and back at work; if they fail, we cut their benefits anyway.

## Just feel the numbers

Underpinning all this is the persistence of a perverse national objective – to see an increase in the number of our citizens who get so deeply in trouble that they need to resort to 'structured' addiction treatment, an unpalatable step many take only when things have deteriorated to the point where their lives afford no other hope of relief.

Through stigmatisation, criminalisation and exclusion, we push people deeper in to these holes and strip away the supports they might haul on to pull themselves out of their troubles, ourselves creating the 'chronic relapsing condition' we locate within the patient. If you want to know how that feels, listen to the voice of this DIP-recruited methadone patient:

"I really did think in my heart that I would be able to make it. But, I got backed into a corner every time. Every angle or way I tried to get up that ladder, I got kicked down. Because I have a criminal record, because I needed training, because I needed experience, because I never had a CIS card, I never had this, I never had that. I was always without a job, no matter how hard I tried to get a job, I could not get a job. I had too much time on my hands ..."[13]

Partly as a result of this process, numbers in treatment mount, and national objectives are met. To maintain, let alone continue to increase this tally, more must emerge the other end, dignified as successful treatment completion and recovery. Now we intend to make it these patients' responsibility to climb out of the holes we have helped push them in to – or else; or else not just prison, but further impoverishment and exclusion.

13 Keene J. *et al.* "A case-study of substitute opiate prescribing for drug-using offenders." *Drugs: Education, Prevention and Policy*: 2007, 14(5), p. 443–456.

## Circles to squares

There is within the current drug policy universe, a logic to these positions; from the point of view of someone trying to reconcile the irreconcilable, they make sense.

According to the only estimates we have, spending per patient[14] has been falling since at least 2002, and now we have a standstill in central funding until 2011, which means further cuts. Yet still we want the treatment entry rate to rise.

Squaring this circle means getting more people out the other end. As the NTA board were told in 2005, "Moving people *through* and *out* of treatment also improves the efficiency of local treatment systems enabling the system to engage with newly presenting clients without having continually to expand capacity" (italics added).

But that is unacceptable unless we can declare them recovered successes. Otherwise we will have to admit that our treatment risks robbing them of the main protection they had (their tolerance to opiate drugs) without this being replaced by robust, individually tailored, above all, expensive anti-relapse supports which could sustain recovery, leaving them more vulnerable than they were before.[15]

Here's another circle to square, because not only are treatment resources more and more squeezed, but beyond the clinic, recovery resources are scarce and likely to get scarcer as the economy falters,[16] housing becomes even harder to find,[17] and socially excluding stigma restricts access to such resources as there are.[18]

In the clinic, spending a few minutes a week on someone's needs is already often the best we can do.[19] Expect that to get worse and notwithstanding the rhetoric, the drive for efficiency savings[20] to push us towards McDonaldisation[21] rather than individualisation of care.

Outside the clinic, the environment generates relapse more effectively than it does recovery. Our treatment leaders in

14 Taking in to account inflation and local contributions as well as central funding.

15 As one part of the NTA wants to get patients out of treatment another recognises that "Retaining patients in optimised treatment is protective against overdose". McCarthy T. et al. *Reducing drug-related harm.* Presentation to National Needle Exchange Forum, 4 April 2008.

16 "A flimsy fightback." *The Economist*: 15 May 2008. http://www.economist.com/displaystory.cfm?story_id=11377022.

17 Local Government Association. "Social housing waiting lists 'rising'" http://www.lga.gov.uk/lga/core/page.do?pageId=565136, accessed 16 May 2008.

18 For several items highlighting increasing awareness of this in Scotland see *SDF* (Scottish Drugs Forum) *Bulletin* March/April 2008.

19 Best D. "Why would anyone claim to be a 'new abstentionist'?" *Druglink*: 2007.

20 Expected to be £50 million per year.

21 The reader is challenged to read this account of the process in Germany and consider if that country could be replaced by the UK without invalidating the story: Kemmesies U.E. "What do hamburgers and drug care have in common: some unorthodox remarks on the McDonaldization and rationality of drug care." *Journal of Drug Issues*: 2002, p. 689–708.

the NTA know that's what it's like[22] but have little idea what to do about it.[23] Their hands are not on these reins. Generally, all they can do is hope that somehow, out in the cities and shires, it will happen – houses unlocked, colleges thrown open, employers open-armed, or at least, enough movement in those directions safely to mop up the 'planned discharges' we hope to increase in number.

A "revolution" across society which replaces stigma with compassion, and in doing so releases the freely given practical and emotional resources of our communities (including those most directly affected) might truly square this circle, and this is the vision of the most vocal of the recovery advocates.[24] The problem is that pinning treatment's colours to fear of crime and before that to fear of infection may not have fostered much in the way of compassion for the 'theys' who threaten 'us'.[25]

Meantime these irreconcilables can be squared and made to seem to fit, first by not recording the failures, then by reserving the right to blame the patients if things go wrong. No wickedness or even intention need be involved or is being imputed – it's just the way the pressures pan out.

## From unthinkable to reality (and back again?)

In Britain now is a strange time when neglect and/or the confluence of forces which before held each other in check are creating realities out of the previously unthinkable.[26] 'It couldn't happen here' no longer seems convincing. It could, and it might.

Within the drug treatment sector, a strong wind is blowing us towards a future in which we and the patients could lose the gains of the harm reduction era without in reality the compensating prize of recovery; an era even more comprehensively geared to harm production than the current one yet without its ameliorating focus on limiting at least some of the damage it creates.

But a wind at our backs is all it is – we are far from there yet and not even fully embarked on the journey. We can still hold the best from our current ground, supplement it with the best from the new recovery movement, and consign its unhelpful hitchhikers to the margins.

Despite under Labour feeling the wind most sharply, under the SNP, Scotland seems to have done just that. There Minister for Community Safety, Fergus Ewing, recently told parliamentarians that stabilisation on methadone was "a form of recovery" and stressed it was important that these patients were not "stigmatised and labelled". "You will not hear any of that language coming from us," he said.[27]

In New York Giuliani backed down under a tide of expert opinion which generated hostile media reaction to his plans.[28] Ironically, the net result was at least partially to reverse the stigmatisation of methadone patients who, unlike 12-step's successes, prefer to keep themselves and their achievements hidden. As in Scotland, another result was to focus on fostering recovery *on* methadone as well as off it, combining recovery with maintenance.

In choosing England's future direction, it may help to stick a flag as well as a finger up to the breeze so we can all see more clearly where it's coming from and where it could be taking us.

**Mike Ashton** (mike.ashton@blueyonder.co.uk)

Editor, Drug and Alcohol Findings (http://findings.org.uk), writing in a personal capacity.

Note: many of the issues raised in this article are expanded on in the fully referenced paper *The New Abstentionists* (http://www.drugscope.org.uk/Documents/PDF/Good%20Practice/Ashton_M_30.pdf). To save space only new or essential citations have been repeated here. The same issues were also addressed in a series of four debates organised by the Conference Consortium (http://www.conferenceconsortium.org) and DrugScope (http://www.drugscope.org.uk). Check their web sites for documents arising from the debates.

22 National Treatment Agency for Substance Misuse. *Business plan 2007/08:* "Access to wider systems of social support, housing, employment and education, for example, has not grown as rapidly as the treatment system itself ... trapping people in treatment who could exit the system if they had access to a job and a home."

23 National Treatment Agency for Substance Misuse. *Business Plan 2007/08*: "However, there is only a limited amount that can be achieved via national initiatives in this area. Increasingly, the focus for facilitating drug misusers' access to local systems of support will be located within the local partnerships that directly control access to resources."

24 Clark D. *The way forward*. Wired In: 2008. http://www.dailydose.net/archives/OverallStrategyMay08_v1.04_Final_DC_110508.pdf

25 McGrail S. *The Great Debate?* 18 April 2008. http://homepage.mac.com/smcg1967/Sara%20McGrail/page14/files/b917acf3e9471265da0d-d8471284286d-27.html: "The investment we've been paying our rent of the back of for the past few years has been predicated on the ability of senior people in the field to 'sell' the concept of drug treatment to the public. This has largely been done on the basis of fear. Firstly fear of disease and secondly fear of crime. Both of these approaches have one thing in common – and that is, that they are based on the assumption that the public will not accept that people who have problems with drug use deserve treatment because they are human beings and have a right to help and support."

26 Examples. Northern Rock, an unthinkable collapse followed by an unthinkable rescue, the first bank nationalisation in modern history. A gaffe-prone "loose cannon" even his own party thought a no-hoper, becomes major of London. (Merrick J. "David Cameron fears 'loose cannon' Boris Johnson will hit his hopes of winning the next election." *The Independent*: Sunday, 4 May 2008).

27 Scottish Drugs Forum. "New drugs strategy will focus on five key priorities." Scottish Drugs Forum Bulletin: May 2008.

28 Winick C. "A mandatory short-term methadone-to-abstinence program in New York City." *Mount Sinai Journal of Medicine*: 2001, 68 (1), p.41–45.

...continued from page 8

| | Do not have accessible toilets | Have entrances that are not barrier-free. | No lifts to allow access to non ground floor premises | Do not employ staff who can use sign language | Do not have materials in braille or large print | Are not capable of producing documents in alternate formats | Do not have accessible bathing facilities (residential care centres) |
|---|---|---|---|---|---|---|---|
| North American treatment facilities | 18 - 20% | 24 - 32% | 40 - 45% | 79 - 84% | 70- 88% | 70% | 26- 31% |
| UK treatment facilities | 57% | 40% | 58 | 61% | 87% | 91% | 79% |

PWD population and typical treatment participation rates [9,10,11]. Indeed, given the population sizes and rates of substance misuse, between 9.75 and 19.5 million PWDs in the United States could be in need of substance misuse treatment.

A number of theories have been explored to examine this disparity, but recent efforts have focused on accessibility issues. Accessibility is a universal concept that incorporates aspects of the physical environment as well as facets of communication and general inclusion. The ability of PWDs to access treatment came into question with a series of studies in North America which found that 18 - 20% of treatment facilities do not have accessible toilets and 24 - 32% have entrances that are not barrier-free. Among those centres in multi-storied buildings, 40 - 45% fail to have lifts to allow access to non-ground floor premises, and among those centres providing residential care, 26 - 31% do not have accessible bathing facilities. Further, when considering communication barriers, most (79 - 84%) do not employ staff who can use sign language, nor do they know how to access an interpreter (80 - 93%). Not surprisingly, most do not maintain written materials in braille or large print (70 - 88%) nor are they capable of producing documents in alternate formats (about 70%) [10-13].

In a series of recently completed studies I have found similar issues to be common in the UK. In pilot research with providers from across the country, I found that 61% of responding facilities do not have a member of staff who is capable of using British Sign Language (BSL) and the majority do not have materials in braille or large print (87%) nor are they capable of producing documents in such formats (91%). Just under a quarter of respondents indicated that they do not have accessible parking on-site (23%) and under half (40%) reported that they do not have accessible entrances to their centres. Among those centres in multi-storied buildings, most (58%) do not have a lift to allow access to non ground floor premises. As was the case in the US and Canada, the majority do not have accessible toilets for client use (57%) and most residential facilities (79%) do not have accessible bathing options.

Clearly, these can be serious impediments to treatment participation. It seems doubtful that someone would attempt to engage in a 30-day residential treatment programme if they could not use the toilet or wash in the interim. Studies are beginning to show the cumulative effect of such barriers. A recent effort noted that 55% of individuals with spinal cord injury and 44% of individuals with traumatic brain injury who seek treatment are denied services based on these types of accessibility concerns. Such denials and barriers to treatment are likely to be unequalled and are certainly cause for concern.

Obviously, there are no quick and easy fixes to a problem that is only now being recognised. However, we are not without options. A simple first step would be an evaluation of our workplaces and materials. A number of guides are available to assist in ensuring that our offices, car parks, and toilets are barrier free and that our written materials are accessible. Being familiar with the accessibility of other providers can aid in the use of appropriate referrals as well. We can educate ourselves to disability etiquette, and be cognisant of the unique abilities, traits, and needs of this highly diverse population. We can also advocate for greater inclusion of PWDs in all facets of our profession and our communities. In sum, we can and must be inclusive.

**Steven L. West** Associate Professor, Department of Rehabilitation Counseling Virginia Commonwealth University, USA.

### References

1. Dunnell, K. Diversity and different experiences in the UK: National Statistician's Annual Article on Society. *Annual Article on Society, Office for National Statistics* 2008. Available online: http://www.statistics.gov.uk/articles/nojournal/NSA_article.pdf

2. Burgard, J. F., Donohue, B., Azrin, N. H., & Teichner, G. Prevalence and treatment of substance abuse in the mentally retarded population: An empirical review. *Journal of Psychoactive Drugs* 2000. 32, 293– 298.

3. Westermyer, J., Kemp, K., & Nugent, S. Substance disorder among persons with mild mental retardation. *American Journal on Addictions* 1996 5, 23– 31.

4. Nelipovich, M.,Wergin, C., & Kossick, R. The Marco model: Making substance abuse services accessible to people who are visually impaired. *Journal of Visual Impairment and Blindness* 1998 92, 567–570.

5. Moore, D., & Polsgrove, L. Disabilities, developmental handicaps, and substance misuse: A review. *The International Journal of the Addictions* 1991 26, 65–90.

6. Heinemann, A. W., Doll, M., & Schnoll, S. Treatment of alcohol abuse in persons with recent spinal cord injuries. *Alcohol Health and Research World* 1989 13, 110–117.

7. Kolakowsky-Hayner, S. A., Gourley, E. V., Kreutzer, J. S., Marwitz, J. H., Meade, M. A., & Cifu, D. X. Post-injury substance abuse among persons with brain injury and persons with spinal cord injury. *Brain Injury* 2002 16, 583– 592.

8. Taylor, L. A., Kreutzer, J. S., Demm, S. R., & Meade, M. A. Traumatic brain injury and substance abuse: A review and analysis of the literature. *Neuropsychological Rehabilitation,* 2003 13, 165– 188.

9. Cherry, L. Institute on alcohol, drugs, and disability: From grassroots activity to systems changes. In A. W. Heinemann (Ed.), Substance abuse and physical disability *New York: Haworth Press* 1993 (pp. 181– 215).

10. West, S. L. Limited access for persons with disabilities in addictions treatment in the U.S. *Journal of Substance Abuse Treatment* 2007 33, 1-5.

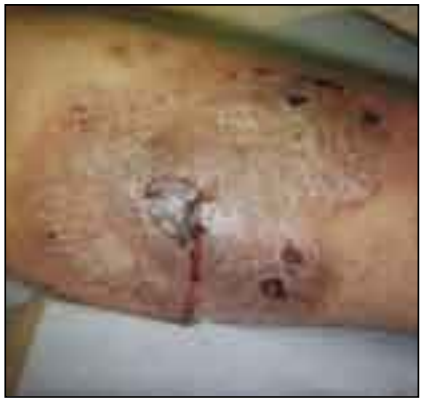
11. West, S. L., Luck, R. S., & Capps, C. F. Physical inaccessibility negatively impacts the treatment participation of persons with disabilities. *Addictive Behaviors* 2007 32, 1494-1497.

12. Voss, C. P., Cesar, K. W., Tymus, T., & Fielder, I. G. Perceived versus actual physical accessibility of substance abuse treatment facilities. *Topics in Spinal Cord Injury Rehabilitation* 2002 7, 47–55.

13. West, S.L., & Graham, C.W. Canadian addiction treatment centre accessibility for persons with disabilities: Results of a national study. *Journal of Substance Use.* (In-Press)

***Marie White*** **takes us from the assessment to the treatment of leg ulcers and includes some excellent graphic guidance. Ed.**

# What to do with those leg ulcers?



## Introduction

I am employed as a clinical nurse specialist with Rochdale Community Drugs Team in the Northwest of England. As Team Leader for the Harm Minimisation Service, a major component of my role is the management of injection related wounds/leg ulceration occurring in past and present injecting drug users.

From identified local need and previous experience in leg ulcer management as a district nurse, I have established a nurse-led clinic for wound/leg ulcer management which has clinical care pathways into "mainstream" primary care tissue viability and secondary care vascular services.

## Assessment

All nurses have a responsibility to their patient group to be well informed in all areas of leg ulcer management [1] and this must apply to nurses dealing with leg ulcers with the past/present injecting drug-using population.

What does the term leg ulcer mean? A useful definition is:

'…. A loss of skin below the knee on the leg or foot which takes longer than 6 weeks to heal.'[2]

The term 'leg ulcer' is not a diagnosis but the manifestation of the underlying process, and successful leg ulcer management is dependent on accurate, competent assessment and the formulation of a differential diagnosis [3].

As with any condition a holistic assessment of a patient with a leg ulcer is essential and should include social and psychological factors as well as a thorough assessment of the ulcer, circulation and the limb [1].

Lack of appropriate clinical assessment of patients with limb ulceration in the community has often led to long periods of ineffective and often inappropriate treatment [4,5,6,7]. I have witnessed this in local community drug teams with nurses not having the required education, knowledge and skills to enable even definition/recognition/identification of underlying physiology of leg ulceration, or its correspondence to past/present injecting drug use.

Research suggests that local service provision for leg ulcers has been based on anecdotal evidence and custom and practice[8]. At very best patients are signposted to mainstream service provision but it rarely happens that patients attend due to a number of factors including previous negative and punitive experiences, fatalistic acceptance linked with behaviour, illicit drug use taking priority over health and patients hiding their continuing drug use from their key worker/methadone provider [9,10,11].

Models of Care [12] suggest that nurses should be employed within needle exchanges to deal with minor infections and provide dressings. However the need for evidence based health care incorporating wound management for this client group has only recently been highlighted at a national level [13].

Patient documentation should inform colleagues of what was found and when, and should also include recommendations regarding management. A clear rationale linking assessment to treatment or referral is vital [1]. In areas such as visual assessment of ulcer bed, pain and quality of life issues, assessment can be very subjective and is only as good as the practitioner performing the assessment [8]. For example applying compression bandaging to a limb where the arterial blood supply is compromised may result in gangrene; and withholding compression bandaging where there is venous insufficiency may result in failure to heal and/or rapid extension of the ulcer.

National guidelines in leg ulcer management stipulate a practitioner performing interventions should be suitably qualified [3]. Dependent on the area of practice, this term can be interpreted in different ways ranging from requiring in-house training to requiring an accredited university qualification. As nurses we are all accountable for our practice and could be called upon to provide a rationale and an evidence base as to our interventions [14]. Therefore it is important to ensure that practitioners recognise that unless there is a tissue viability nurse specialist employed within their organisation they have a duty to practice within the local Primary Care Trust's requirements, wound formularies, guidelines and policies for leg ulcer management, and also within the remit of the service level agreement and with the involvement of the tissue viability lead. If these policies, procedures and care pathways are not in existence, vicarious liability lies solely with the practitioner performing the care and could potentially lead to personal, professional and employer litigation if the care provided is found to be lacking.

## Practicalities of provision

Depending on locality and commissioning, provision can vary from: an agreed application of a conservative dressing from local PCT; wound formulary; or application of a clinical care pathway/referral to either a district nursing service or

tissue viability/vascular service; to on-site leg ulcer management. Within my substance misuse directorate, practitioners who recognise their limitations in this field have developed on-site clinics in collaboration with their local district nursing service to provide leg ulcer management operating from needle exchanges whilst they obtain the necessary qualifications and competencies for assessment, classification and treatment of wounds through to comprehensive leg ulcer management provision.

### Holistic assessment

There are many factors influencing healing and this means that wounds/ulcers cannot be treated in isolation and any wound bed preparation must be part of an ongoing, holistic wound management strategy [15].

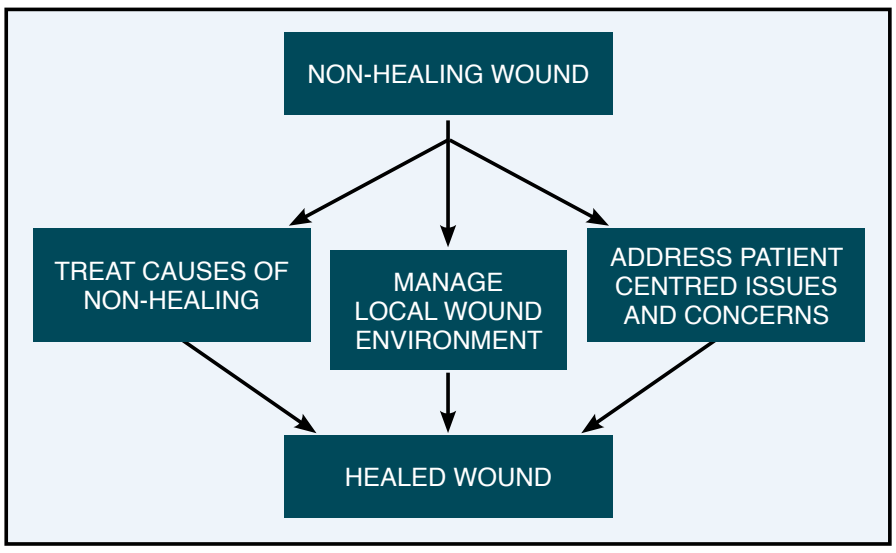
The starting point in wound management is the patient assessment.

A good assessment will enable practitioners to:

- Diagnose the cause of the wound
- Identify causes of non-healing
- Identify patient concerns
- Formulate a plan of care which encompasses these elements

Therefore it is important to treat the whole person who presents with a wound/ulcer and not just the hole in the patient.

### Holistic wound care strategy




| Predominant Tissue Type | Example | Aim of Treatment | Suitable Dressing |
|---|---|---|---|
| **Necrotic tissue + ischaemia** |  | **To keep dry** | **DO NOT USE DEBRIDING AGENTS**<br>**Use iodine based products**<br>**Leave exposed if completely dry** |
| **Necrotic tissue + NO ischaemia**<br>i.e. The wound has a covering of black tissue |  | **To debride and remove eschar** | **Dry necrosis: Needs moisture**<br>Hydrocolloid or Hydrogel or Hydrogel sheet or Moistened Hydrofibre<br>**Wet necrosis:** Needs absorbency Foam dressing with or without Hydrofibre or Alginate |
| **Sloughy tissue**<br>i.e. devitalised yellow tissue covering the wound |  | **To remove slough and excess exudate** | **Dry slough:**<br>Hydrocolloid or Hydrogel or Moistened Hydrofibre flat sheet<br>**Wet + shallow:** Foam<br>**Wet + deep:** Foam with Hydrofibre or Alginate<br>**Consider larvae therapy** |
| **Granulating**<br>i.e. clean healthy red granulation tissue |  | **To promote granulation and stimulate healing** | **Dry + shallow:** Low adherent dressing Or Hydrocolloid<br>**Dry + deep:** Hydrogel sheet or Hydrocolloid + Hydrogel<br>**Wet :** Foam with or without alginate or hydrofibre<br>**Very Wet:** Low adherent dressings + dressing pads |
| **Epithelialising**<br>i.e. pale pink healing tissue |  | **Protect tissue and promote Epithelialisation** | **Low adherent dressing or Film dressing or thin Hydrocolloid** |
| **Critically colonised or infected**<br>i.e. malodorous with clinical signs of infection |  | **To manage infection, and reduce bacterial burden** | **Use anti-microbial agent:** Iodine or silver or honey<br>**Systemic antibiotic therapy should be considered in the presence of clinical signs of infection**<br>**NB: Avoid occlusive dressings if anaerobic infection suspected or confirmed** |

### Wound care formulary

Matching a dressing to a wound/patient is the responsibility of a suitably qualified practitioner who should determine wound condition and establish treatment objectives following a full assessment. Wound tissue changes as it travels through the wound healing stages; for this reason different types of wound dressings will be required to appropriately mange the wound. It is not unusual to see a combination of tissue types within one wound. In this situation the clinician needs to prioritise the aim of treatment from necrotic to sloughy to granulation to epithelialising [16]. A wound care formulary should be used as an educational tool to guide practice and does not replace professional judgement.

### The main components of leg ulcer treatment

- Correct underlying cause of the ulcer, for example by improving the underlying venous or arterial blood flow

*...continued overleaf*

...continued from previous page

- Create an optimal local environment for wound healing
- Improve the wider intrinsic and extrinsic factors that may delay healing-poor mobility, malnutrition and psychosocial issues
- Prevent avoidable complications-infection, bandage trauma
- Maintain healed ulcers

**Marie White,** Clinical Nurse Specialist, Rochdale Community Drugs Team.

**References**

1. Murray J Leg Ulceration part 2: patient assessment. Nursing Standard 2004 19(2):45-53.
2. Cullum N & Roe B Leg Ulcers: Nursing Management: a research based guide.London.Bailliere Tindall 1995.
3. Royal College of Nursing Clinical Guidelines-The Nursing Management of Patients with Venous Leg Ulcers. London.RCN 2006.
4. Cornwall JV, Dore CJ&Lewis JD `Leg ulcers: epidemiology and aetiology`.British Journal of Surgery 1986 73(9):693-696.
5. Elliot E, Russell B & Jaffrey G `Setting a standard for leg ulcer management`Journal of Wound Care 1996 5(4):173-175
6. Roe BH, Luker KA, Cullum NA, Griffiths NA, Griffiths JM &Kenrick M `Assessment prevention and monitoring of chronic leg ulcers in the community: report of a survey` Journal of Clinical Nursing 1993 2 (5):299-306
7. Stevens J, Franks PJ, &Harrington M A community/ hospital leg ulcer service. Journal of Wound Care 1997 6(2):62-68
8. Russell L. `The importance of wound documentation and classification`. British Journal of Nursing 1999 8(20):1342-1354
9. Finnie A &Nicolson P. `Injecting drug use: developing a drop-in wound care clinic`.British Journal of Nursing 2002a 11(12):S8-S20.
10. Grau L, Arevalo B, Catchpool C & Heimer R `Expanding Harm Reduction Services Through A Wound and Abscess Clinic`. American Journal of Public Health 2002 92, 12.
11. Mustasa HCF `Risk factors associated with non-compliance with methadone substitution therapy (MST) and relapse among chronic users in an outer London community`. Journal of Advanced Nursing 2001 35, (1):97-107.
12. National Treatment Agency Models of Care London 2002.
13. National Treatment Agency Non-medical prescribing, patient group directions and minor ailment schemes in the treatment of drug misusers. London 2007.
14. Nursing and Midwifery Council Code of Professional Conduct London.NMC 2004.
15. Falanga V. 'The chronic wound: impaired healing and solutions in the context of wound bed preparation'. Blood Cells Molecules and Dieases, 2004 32; 1: 88-94.
16. Gray D, White R, Cooper P, & Kingsley A Understanding applied wound management. Wounds UK (2005) 1(1): 62-2

***Andy Lane*** **draws our attention to the risks of combining of opioids and cyclizine. Ed.**

# The dangers of prescribing cyclizine to opiate injectors..... a reminder

I was recently involved in a coroner's inquest of a client of mine whose death certificate stated 'pulmonary thrombo embolism due to deep vein thrombosis'. He was a known regular groin injector. Toxicology was positive for heroin, methadone and cyclizine. It became apparent during the inquest that the effects and risks of combining 'crushed' cyclizine tablets with heroin, diamorphine or methadone injections was not common knowledge within primary care or hospital services.

Cyclizine is an anti emetic used in the treatment of nausea, motion sickness, vomiting and vertigo. It is classed as a non sedating anti-histamine.

Diconal became popular on the black market among opiate dependent users as a morphine related analgesic a number of years ago. It is manufactured as dipipanone (opiate) and cyclizine in a combined tablet form.

Heavy long-term heroin users found they no longer achieved a 'rush' from injecting and discovered that Diconal dissolved and injected provided this. A major problem was the presence of silicon in the preparation, which resulted in a number of limb amputations in these clients. There is an opinion that the popularity of Diconal among opiate injectors may be more due to the cyclizine component that the dipipanone [1].
Today Diconal is very rare on prescription however cyclizine remains available and is also known as Valoid, a travel sickness medication. The prescribed dosage is 50 mg tablet tds or 50mg/ml injection [2]. It is also a component of Cyclimorph and Migril.

There is a large regional variation in the popularity of cyclizine amongst drug injectors; certainly Wigan and Leigh have their problems as do St Helens and other parts of Merseyside. Pharmacologically it is anti-histaminic, anti-serotonic, and has an anaesthetic and vagolytic effect.

Gott [3] described three 17-year-old boys each having swallowed 750mg cyclizine. They were euphoric showing: tachycardia; raised blood pressure; exhilaration; dilated pupils; tremulous, slurred speech; two described hallucinations; and one had a grand mal fit. All recovered in 12 hours.

The common practice is to combine cyclizine with heroin or methadone injection. This involves dissolving a chalk-based tablet and mixing it with the opiate and injecting it into a major vein, often the groin. It enhances the opiate effect, causes intense stimulation with methadone injection but also produces erratic behaviour, loss of judgement and amnesia. This leads to risky behaviour and the likelihood of injury or criminal activity. The cyclizine tablet is slow to dissolve when injected and has an irritant effect on the vein. Sediment increases the risk of deep vein thrombosis (DVT) and infection. Sue Ruben [1] published a paper discussing this behaviour and stated that dependence occurred in half the clients surveyed and most described a compulsion to repeat the experience.

This particular client of mine was extremely chaotic, volatile and very difficult to engage in treatment, and he frequently tested positive for cyclizine. It became apparent that the source of his cyclizine was via primary care where a number of doctors had prescribed it at his request in good faith.

From a drug service point-of-view the combination of opiate and cyclizine makes treatment and client wellness very difficult. The general behaviour of clients on this combination is often problematic and engagement can be difficult. It is important that practitioners are aware of the interactions with opiates in this group of clients and assess the clinical need carefully before prescribing cyclizine.

**Dr Andy Lane,** GP Specialist, Clinical Lead Wigan and Leigh Drugs and Alcohol Service ( Part of Greater Manchester West, NHS. Foundation Trust).

**References:**

1, Ruben. S. et al Cyclizine Abuse among a Group of Opiate Dependents Receiving Methadone, British Journal of Addiction, 1989 84, 929-934

2. BNF BMJ Publishing Group Ltd, Tavistock Square, London, and RPS Publishing, 1 Lambeth High Street, London 2008

3. Gott, P.H Cyclizine toxicity, New England Journal of Medicine, 1968 279,p.596. cited Ruben. S. et al Cyclizine Abuse among a Group of Opiate Dependents Receiving Methadone, British Journal of Addiction, 1989 84, 929-9343,

*…continued from page 3*

their own good'? The desire to go your own way and make your own choices for better or worse may be an essential part of the change process and should be appreciated and encouraged. The resistance to being controlled may be the force that rejects the addiction in the end.

**Unhelpful services:** We need to consider the reasons why people may not perceive services as being likely to be of any help to them:

- Maybe we aren't 'marketing' ourselves very well by making it clear to people what it actually is that we could do for them. This we can address.
- Maybe we aren't actually providing what people need, or at least in the way they need it. So let's ask them. And let's listen to what they say.
- And maybe some of the things they actually need are not within our role to provide anyway – self-belief and confidence, strong and faithful friends, meaningful and satisfying work, and so on.

### So how did they manage it?

The same way we all do when we want to make changes, i.e. they made the necessary changes when they decided they wanted things to be different and when this seemed possible [7]. Treatment can only support this change, not create it, and we should be aware that treatment can also inhibit change.

The evidence is that the processes (in psychological terms) are broadly similar for people in treatment to those who manage without it. Basically, people change when they realise that to continue as they are would be more painful than to change, and they can see that change is possible. In addition to this, social support is a big factor. Prochaska and DiClemente [8] established this some years ago, and the *Cycle of Change* is based on these findings.

### Is self-change a good thing and to be encouraged?

Well it's cheaper for a start. Services are expensive, and we should target them to the people who really need them. More of the quality we would all like to provide and less of the quantity for the sake of it - less McDonalds, more home cooking.

The treatment experience can be very disruptive to people's lives. If you're managing change within your own resources you have more control over doing it the way that works for you, and for the rest of your life.

Wrong though it may be, the fact is that the 'addict' identity has a great deal of stigma attached to it, as well as a lot of inbuilt and powerful negative messages of hopelessness and powerlessness. It's good that people are resistant to taking on those messages.

And if you are managing yourself, or with the help of the resources around you, you are likely to feel better than if you ask someone else to do it for you. And success breeds success as we realise we *can* manage our lives.

Remember empowerment? It was about allowing, encouraging and helping people and communities to help themselves. It's not the 90s anymore, but it's still worth promoting empowerment despite a Government that increasingly knows what's best for us. Let's bring back empowerment.

And finally, the concept of natural recovery offers a more positive focus, on what people *can* do, rather than what they *can't* do, on accomplishments rather than problems. This is a fundamentally different perspective with enormous potential. We already know lots about what it seems people can't do, let's try and understand more about what they can do. Let's focus on health and social care, rather than on illness and social control.

So we know that many people can and will manage without us. But is there anything useful we can learn from this?

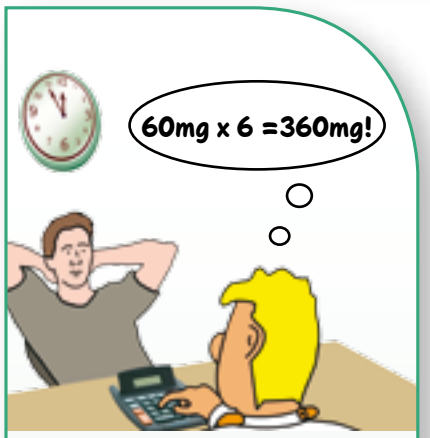
There is a lot we can learn from people who don't want to use our services, in particular about how we could make services more attractive and relevant. We can accept and affirm that most people *can* and *do* manage without us, and plan our health strategies accordingly, with an emphasis on empowerment, stepped care in drugs services, and on health promotion approaches for the general population. We can give the message that natural recovery is possible, rather than giving messages of powerlessness we may be unintentionally reinforcing. We can value and affirm people's desire to do things *their* way, rather than ours or the Government's. We can work *with* people and their processes of change rather than doing stuff *to* them. And for a minority who find change particularly difficult at times, we still have a role in supporting them in achieving this. All recovery is essentially 'self-change' and the role of treatment is to support this process – and indeed, this is all that treatment can hope to do.

So let's change how we think about services and people with drug problems. Let's change how we think about change.

**Anthony Hewitt,**
Freelance Consultant and Researcher.

#### References

1. Klingemann, H. et al (eds): Promoting Self - Change From Problem Substance Use: Practical Implications For Policy, Prevention and Treatment *Kluwer Academic Publishers* 200.
2. Sobell, L. et al: Natural Recovery from Alcohol And Drug Problems; Methodological Review Of The Research With Suggestions For Future Directions Addiction 2000 Vol.95 (5) pp.749-764 (Sobell is the key researcher in this area).
3. Cunningham, J: Untreated Remissions from Drug Use; The Predominant Pathway, *Addictive Behaviours* 1999 Vol.24 No.2 pp.267 -270.
4. Cunningham, J. & Breslin, F: Only One in Three People with Alcohol Abuse or Dependence Ever Seek Treatment *Addictive Behaviors* 2004 29 pp.221-3.
5. Blomqvist, J: Paths to Recovery from Substance Misuse: Change of Lifestyle and the Role of Treatment *Substance Use and Misuse* 1996 31 (13) pp.1807-1852.
6. Biernacki, P: Pathways from Heroin Addiction: Recovery without Treatment PA Temple University Press Philadelphia 1986.
7. Edwards, G. Editorial note: Natural recovery is the only recovery *Addiction* 2000 Vol.95 no.5 p.747.
8. Prochaska, J. & DiClemente, C: Towards a Comprehensive Model of Change in Miller, W. & Heather, N. (eds.): Treating Addictive Behaviours – Processes of Change (2nd. ed.) *Plenum Press* 1998 pp. 3-27.




# Dr Fixit on morphine sulphate

***Chris Ford*** **gives advice on the use of morphine sulphate, dihydrocodeine and codeine for drug dependency. Ed.**

***Dear Dr Fixit***

*I am having enormous problems with prescribing for one of my patients, Tony. He is keen to settle on maintenance and get back to work. He has tried methadone mixture (up to a good therapeutic dose of 110mg) and buprenorphine (up to 32mg) and he was unable to settle on either. With methadone he felt and looked like a zombie! Buprenorphine just didn't work for him. He tried both for over three months. He has gone back to smoking heroin because he says he feels and functions well on this but he is concerned about getting arrested and it has also had a negative effect on his asthma.*

*Is there anything else I could try? He has read that they use morphine sulphate in Europe. Would that be a possibility?*

***Answer provided by Dr Chris Ford,*** *GP & Clinical Lead for SMMGP*

Thanks for your question and I have been in almost the same situation with a few patients – in my experience, methadone and buprenorphine certainly don't suit everybody.

I have on occasion used codeine and dihydrocodeine and found them helpful for certain individuals. We need to be aware that we are using them outside of license in the UK. The 2007 Clinical Guidelines do mention these drugs in section 5.6.5, although it states that they shouldn't normally be used in the community [1]. The guidelines suggest that both drugs are hard to supervise and need frequent dosing but can be used in some circumstances [2] and acknowledge that dihydrocodeine (section 5.6.5.1) does have a small evidence base. A trial undertaken in Scotland concluded that an equivalent dose was 2.5mg methadone to 30mg dihydrocodeine (for more of this see Roy Robertson's article, page 4). Most of my experience with dihydrocodeine has been when using it as a detoxification drug but I have used it occasionally as a maintenance option and tend to use the 60mg or 120mg tablets. Both dihydrocodeine and codeine have been useful with dependence to over the counter medication and are a lot safer than Nurofen Plus.

I have also used morphine sulphate, again mentioned in the 2007 Clinical Guidelines, which highlight the fact that it is used elsewhere in Europe with patients similar to Tony, who fail to tolerate or stabilise on methadone (section 5.6.5.2[1]). One trial in Austria showed a high retention rate (94%) with slow-release oral morphine and concluded that there was good acceptance of slow-releasing oral morphine [3]. Another study undertaken by the same group but using small numbers (64) compared the effectiveness of slow-release morphine and methadone for opioid maintenance therapy and found that 86% of patients completed the study, with a mean methadone dose of 85 mg and a mean slow-release morphine dose of 680 mg. No significant differences in retention or use of illicit substances (opioids, benzodiazepines, cocaine) were observed, irrespective of treatment group or medication. However, patients receiving slow-release morphine had significantly lower depression and anxiety scores and fewer physical complaints. They concluded that oral slow-release morphine is as effective as methadone in the treatment of opioid dependency, with comparable safety and tolerability and a greater benefit on patient well-being. I really like their other conclusion which was 'Greater pharmaceutical diversity represents a modern development in mainstream medicine. Slow-release morphine might represent a future treatment option that will improve long-term outcomes for this target group' [4].

In the case of Tony, I would explain the three drugs to him. He has already indicated a preference for morphine sulphate and I'm told it feels the closest to heroin. When transferring people to slow-release morphine sulphate, I find that each patient differs regarding the amount they need to stabilise on. In my experience it is usually double to quadruple the dose of methadone (because of it's shorter half-life). But it is important to titrate the dose up in the same way as you do for methadone.

A review of the literature indicates that large doses of morphine are used when treating opiate dependency (mean dose methadone 85mg and morphine 680mg- around eight times the dose of morphine as compared to methadone). This has been my own experience, and when I asked my two current patients on slow release oral morphine sulphate, they reported being happy with their doses. The first person was transferred from 60mg methadone and is now on 360mg slow release oral morphine sulphate, which I realise is a six times differential. The other has transferred to slow release oral morphine sulphate from heroin having come to us after failed methadone treatment. He has settled well on 400mg.

It is clear that morphine sulphate, dihydrocodeine or codeine are not right for everybody and should only be used when other options have failed. But not to use them at all further limits our 'prescribing tool box'. Let me know how you get on.

**References**


1 UK Health departments Drug Misuse and Dependence: UK guidelines on clinical management: The Stationery Office 2007

2 Robertson JR et al Addressing the efficacy of dihydrocodeine versus methadone as an alternative maintenance treatment for opiate dependence: a randomised controlled trial. Addiction 2006 101 (12), 1752-1759

3 Dominik Kraigher Use of Slow-Release Oral Morphine for the Treatment of Opioid Dependence European Addiction Research 2005 (11) 145-151

4 Harald Eder et al Comparative study of the effectiveness of slow-release morphine and methadone for opioid maintenance therapy. *Addiction* 2005 (11) 100 (8), 1101-1109

# Dr Fixit on deep vein thrombosis

***Penny Schofield*** **gives advice about the treatment options for deep vein thrombosis. Ed.**

***Dear Dr Fixit***

*Adam has been a patient of mine for six weeks. He has a long history of groin injecting but now wants to stop. He is beginning to stabilise on 120mg of methadone mixture but continues to inject about once a week. We have frequently discussed using other sites for injecting and I even found him a vein in his left upper arm. He presented yesterday with an obvious deep vein thrombosis in his left leg. He agreed to attend for a Doppler which confirmed a new and an old clot in his leg but he absolutely refused to go into hospital.*

*I have started him on low molecular heparin but it's a drug I'm not used to using and wanted your help.*

*Have I done the right thing or should I have refused to treat him if he wouldn't go into hospital? Is warfarin better with all its problems? He has chronic hepatitis C- should that affect my choice of drugs? He also has an alcohol problem, although he has done very well and reduced from 60 units to 24 units a week since being in treatment and hopes to stop all together.*

***Answer by Dr Penny Schofield,*** *Clinical Director, Bridge View Drug Treatment Service.*

It is one of the challenges of looking after patients with problems relating to substance misuse that one finds oneself in grey areas where there is no perfect solution. I think you have taken the best decision in the circumstances. Clearly the diagnosis of deep vein thrombosis (DVT) is reasonably certain and anticoagulation is the treatment of choice, normally continued for at least three months.

Prior to the development of low molecular weight heparin (LMWH) the required treatment was initial anticoagulation with unfractionated heparin for several days as an inpatient. LMWH heparin as an outpatient is now routine in many areas. It can be given as a once daily dose and has a more predictable effect on coagulation allowing treatment to occur without blood monitoring. It has been demonstrated to be as effective and probably safer than unfractionated heparin for the initial management of DVT with selected patients. There appears to be no difference in clinical effectiveness between the different LMWHs, four of which are available on prescription in the UK [1].

Before starting LMWH base line bloods should be taken. These include platelet count, PT, APTT to rule out any clotting problems, and renal and liver function tests. The dose of LMWH is calculated according to body weight. LMWH is excreted by the kidneys and the dose may need to be decreased in kidney failure and in severe liver failure where clotting is affected. LMWH can cause thrombocyopenia and reversible increase in ALT [1]. The main side effect of LMWH is pain and irritation at the injection site.

You ask if warfarin is a better choice. A Cochrane Review published in April 2003 evaluated the efficacy and safety of long-term treatment of DVT with LMWH as compared to Vitamin K antagonists. The authors concluded that LMWH was possibly as effective and that treatment was significantly safer and might be a safe alternative for some patients [2]. There are no randomised control trails comparing LMWH with coumarins. Non-controlled trials have reported demonstrating safety and effectiveness of low molecular weight heparin in IV drug users with DVTs [3].

The decision will rest on Adam's preference, his stability and his commitment to attend for monitoring. The perception in our anticoagulation monitoring clinics, both community and hospital based, is that clients with substance misuse problems are poor attenders, and LMWH is widely used. Apart from poor attendance there are other aspects of life style– poor diet, erratic alcohol intake, injury and intoxication- that make warfarin a less safe option. On the positive side, attendance for INR is an opportunity to monitor progress.

In addition to anticoagulation your patient should be seen regularly to monitor progress of the clot and to check for complications. Some areas now have a nurse led DVT service. If such a service is available in your area the specialist nurse can visit Adam daily at home, administer the LMWH, provide information and advice and assess progress. Post-thrombotic syndrome is common following DVT and can be significantly reduced by wearing appropriately fitting compression stockings. These can be fitted by the DVT nurse, but do need to be worn for 2 years to be effective [1]!

The presence of hepatitis C should not affect management, although clearly appropriate advice with respect to disposal of needles and management of bleeding is essential. If hepatitis C treatment is started, platelet monitoring is important as both LMWH and ribovarin can cause thrombcytopenia. However in both cases this is mild and unlikely to require changes in treatment. Interferon is associated with an increase in warfarin concentration and will require tighter monitoring of INR.

Lastly there is the question of Adam's alcohol intake. Heavy alcohol use causing liver dysfunction may potentiate the effect of warfarin, but drinking within safe levels has little effect [4]. Alcohol intake, unless there is severe liver damage, does not affect LMWH.

**References**


1 Winter et al Procedures for Outpatient Management of Patients with Deep Venous Thrombosis British Society for Haematology 2003.

2 Cochrane Review 2001.

3 Mackenzie et al High prevalence of iliofemoral venous thrombosis with severe groin infection among injecting drug users in North East Scotland: successful use of low molecular weight heparin with antibiotics. Postgrad Med J 2000:76:561 – 565.

4 British Columbia Medical Association. Initiation and maintenance of warfarin therapy 2004.

# BULLETIN BOARD

**SMMGP's 3rd National Conference - Primary Care Drug Treatment** - "End of the line, or part of the journey?" How to optimise patient choice & opportunity
**Venue:** Bristol Mariott Royal Hotel, College Green, Bristol
**Date:** Friday 26 September 2008
**Cost:** £135
For more information contact
**shoc.admin@googlemail.com**

**RCGP Certificate in the Management of Drug Misuse National Face to Face Training Events for Part 1**
**Thursday 25th September 2008,** London
**Monday 10th November 2008,** London
Please contact Lorna Boothe,the Part 1 Coordinator **lboothe@rcgp.org.uk** to enquire or book places on Part 1 Courses

**Royal College of General Practitioners Introductory Certificate in Sexual Health** - an educational tool for generalist clinicians and practice nurses already working in general practice providing a basic grounding in sexual health issues.
**Monday 29 September 2008 9.30-16.30** RCGP, 14 Princes Gate LONDON
**Friday 3 October 2008 9.30-16.30** Palace Hotel, Oxford Street MANCHESTER
For more information contact E-mail: **rfleet@medfash.bma.org.uk**
Tel: 020 7383 6801 Fax: 0870 442 1792

**"From Here to Recovery - Transforming the Journey"**
Second Annual Recovery Conference
"Employment as a Vehicle to Recovery - Developing Pathways Back to Work"
**Venue:** NatWest Rowley Mile Racecourse, Newmarket, Suffolk CB8 0TF
**Date:** Tuesday 7 October 2008
**Cost:** £160.00 per delegate
For more information contact Alison Wigginton Tel: 01707 284951
E-mail: **a.wigginton@herts.ac.uk**

**Mental Health Today**
**Venue:** Manchester Central, Manchester
**Date:** Tuesday 11 November 2008
For more information, please contact E-mail: **info@pavpub.com**

**Society for the Study of Addiction's Annual Symposium**
Addiction Across the Lifespan, Tracking Processes of Recovery
**Venue:** Park Inn, York
**Date:** Thursday 13 - Friday 14 November 2008
For more information contact Graham Hunt
E-mail: **membership@addiction-ssa.org**

**Release Conference: Drugs, Race and Discrimination**
**Venue:** Hampsted Theatre, London. London
**Date:** 18th September 2008
For more information visit:
**http://releaseorgu.eweb101.discountasp.net/latest_conference.html**
Or phone: 020 7749 4044 Email: **jacqui@release.org.uk**


## NETWORK Production

Editor:
Kate Halliday smmgp@btinternet.com

Advisory Editor:
Dr Chris Ford
Clinical Lead SMMGP

Associate Editors:
Jim Barnard,
Policy Officer SMMGP
Jean-Claude Barjolin,
SMMGP Associate
Susi Harris,
Clinical Lead for Substance Misuse, Calderdale
Peter McDermott,
Policy Officer Alliance

Contact:
**National Treatment Agency**
**8th Floor, Hercules House**
**Hercules Road**
**London SE1 7DU**
**Phone 0151 632 0409**
**website www.smmgp.org.uk**

email: Kate Halliday
smmgp@btinternet.com

**SCHERING-PLOUGH LTD**
The production of this newsletter was sponsored by Schering-Plough. Schering-Plough did not contribute to the editorial content

**Network ISSN 1476-6302**

*SMMGP works in partnership with*

Royal College of General Practitioners

NHS
*National Treatment Agency for Substance Misuse*